EPIC
Enhancing Person-centred care In Care homes

Optimising Intervention Implementation in the EPIC trial

Claire Surr[1], Sharon Jones[2], Kayleigh Burton[3], Liz Graham[3], Rebecca Walwyn[3], Robert Cicero[3]
[1]Leeds Beckett University, [2]University of Bradford, [3]Leeds Institute of Clinical Trials Research, University of Leeds

LEEDS BECKETT UNIVERSITY

UNIVERSITY of BRADFORD
School of Dementia Studies

ctru
Leeds Institute of Clinical Trials Research

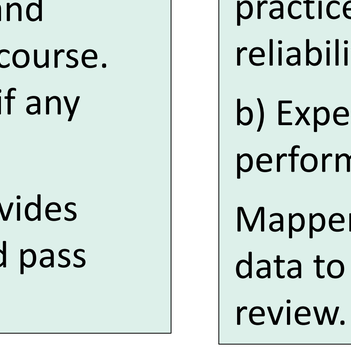
UNIVERSITY OF LEEDS

Background to the EPIC trial

At least two-thirds of people living in care homes have dementia[1] and many develop behaviours, such as agitation[2]. This can be upsetting for them, for other residents and difficult for care staff to support[3,4,5]. These behaviours are often linked to poor quality care[6]. Research shows that training staff in the principles of person-centred care provides them with the skills they need to prevent and support distressing behaviours[7]. However, without extra support for staff to build on their training, these benefits soon disappear[7]. Dementia Care Mapping[8] is a tool that has been used to help staff to continue applying person-centred care training in practice. However, there is limited robust research about how effective it is. It is also a relatively complex tool to master.

Dementia Care Mapping (DCM™)

DCM™ involves observing the experience of care from the point of view of people with dementia and then feeding this back to staff, who use this information to look at ways to improve. The below illustrates the DCM 'cycle'.



The EPIC trial is looking at whether DCM is effective and good value for money when used for this purpose in care homes.

EPIC trial design

Once residents, relatives and staff have **consented** to take part and provided **baseline data**, care homes are **randomly allocated** (3:2) to receive either Usual Care (UC) + Dementia Care Mapping (DCM) or UC alone.

Care home staff at the DCM homes receive standard training to become 'mappers'. They then undertake **3 cycles of DCM** at around 3, 8 and 13 months post-randomisation. Mappers are supported by DCM experts for their first cycle.

Staff and DCM experts provide **data to evidence intervention delivery** in the care homes.

Residents, relatives and staff provide trial **outcome data** at 6 and 16 months post randomisation in all participating homes.

DCM delivery

The intention in the EPIC Trial was to **a)** ensure intervention fidelity and **b)** monitor adherence via the following means:

1. Mapper credentials

a) In consultation with the Care Home Manager (see figure 1), Researchers identify two members of staff at each home who meet the criteria to be a 'mapper'. Mappers receive an information sheet, discuss the role and provide consent.

b) Suitability, eligibility and consent data collected.

2. Mapper training

a) Standardised training is provided by DCM trainers from the University of Bradford – this is a 4 day course with assessment, feedback and criteria for passing the course. Re-sits are undertaken if any elements are failed.

b) The DCM trainer provides data re: attendance and pass mark.

3. Delivery with feedback

a) The first 'cycle' of DCM is undertaken with DCM expert support. This allows for consolidation of skills in practice and inter-rater reliability assessment.

b) Expert rating of performance provided.

Mappers send raw mapping data to the research office for review.

4. Maintenance

a) Thereafter mappers are required to undertake cycles two and three on their own. They are provided with dates to do so at the outset.

b) Mappers send raw mapping data to research office for review, alongside data regarding staff attendance at briefing and feedback sessions.

Problems encountered

During the pilot phase (first few homes) problems with implementation were identified:

Mappers recruited with sub-optimal skills.

Some mappers dropped out prior to the training course, meaning more had to be recruited.

Mappers unable to attend training at the last minute (commitments at the care home)

Some mappers overwhelmed by the intensity of the course.

Difficulty scheduling suitable dates for expert support .

Last-minute cancellations.

Delay in producing the DCM report due to time pressures and lack of confidence.

From early experience, it was felt that some mappers may not remember, or be motivated, to continue with later cycles without support.

Solutions

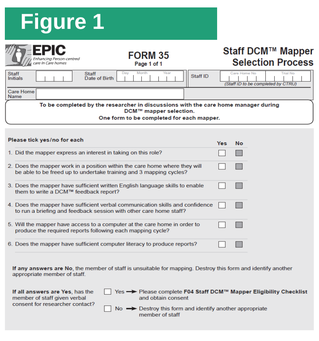
Problems were countered via the following means, with the Clinical Trials Research Unit (CTRU) as a central point of contact:

- Provision of additional materials to support mapper selection (researcher guidance, information for mappers, option to speak to a DCM expert to discuss the role).
- **Early** recruitment of mappers to allow staff rota scheduling to fit with training.
- Researchers emphasise key importance of mapper role to the research, and discuss time commitments with manager & mappers.
- Mappers asked to write a 500 word piece on what they understand by DCM and why they want to be a mapper. This is reviewed by the DCM expert and CI. Mappers contacted by CI / expert if any concerns. Problems fed back to the researchers.

- DCM expert support dates scheduled **early –** at time of CH consent.
- Researchers speak to CH manager and rota manager to ensure mappers will be given time to map within usual working hours.
- CTRU chase mapping data via the DCM experts.

- CTRU monitor dates each cycle is due and send reminder emails, text messages and newsletters to mappers, along with mapping materials ahead of each cycle.
- Any issues flagged as a problem by the experts at cycle one are followed up, and DCM experts may provide further telephone support.
- Missing mapping data chased via the DCM experts.

Figure 1



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Staff DCM™ Mapper Selection Process

Staff Initials | Staff Date of Birth | Staff ID (Staff ID to be completed by CTRU)

Care Home Name

To be completed by the researcher in discussions with the care home manager during DCM™ mapper selection.
One form to be completed for each mapper.

Please tick yes/no for each	Yes	No
1. Did the mapper express an interest in taking on this role?	☐	☐
2. Does the mapper work in a position within the care home where they will be able to be freed up to undertake training and 3 mapping cycles?	☐	☐
3. Does the mapper have sufficient written English language skills to enable them to write a DCM™ feedback report?	☐	☐
4. Does the mapper have sufficient verbal communication skills and confidence to run a briefing and feedback session with other care home staff?	☐	☐
5. Will the mapper have access to a computer at the care home in order to produce the required reports following each mapping cycle?	☐	☐
6. Does the mapper have sufficient computer literacy to produce reports?	☐	☐

If any answers are No, the member of staff is unsuitable for mapping. Destroy this form and identify another appropriate member of staff.

If all answers are Yes, has the member of staff given verbal consent for researcher contact?
☐ Yes → Please complete **F04 Staff DCM™ Mapper Eligibility Checklist** and obtain consent
☐ No → Destroy this form and identify another appropriate member of staff

References
[1]National Audit Office, *Improving services and support for people with dementia*, 2007, The Stationary Office: London
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[4]Banerjee, S., et al., *Quality of life in dementia: more than just cognition. An analysis of associations with quality of life in dementia.* Journal of Neurology, Neurosurgery and Psychiatry, 2006. **77**(2): p. 146-48.
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[7]Kuske, B., et al., *Nursing home staff training in dementia care: a systematic review of evaluated programmes.* International Psychogeriatrics, 2007. **19**(5): p. 818-41
[8]Bradford Dementia Group, *DCM 8 User's Manual.* 2005 Bradford. University of Bradford.

Discussion

Introducing methods to enhance delivery was seen as an appropriate and necessary approach when balanced against the alternative – i.e. the possibility of completing a definitive, pragmatic trial with potential for a negative result arising from sub-optimal implementation rather than actual intervention ineffectiveness.

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Contacts Professor Claire Surr c.a.surr@leedsbeckett.ac.uk Liz Graham e.h.graham@leeds.ac.uk